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A New Year's Health Resolution

ANOTHER record health year has just closed. In spite of continued economic disturbance, during which large numbers of families have felt the pinch of want, the health of the people has continued good. The deathrate was either the lowest or certainly not far from the low point of all time. Progress in the control of the preventable diseases clearly has continued unabated.

The beginning of a new year is, however, the occasion not only for gratification over past performances; it is also a good time to look forward to future responsibilities. What are some of the problems that should receive the attention of those responsible for protecting the public health? Is there danger that as the economic depression lifts, we may enter a period of health depression? There are many well-informed health workers who fear this contingency, and this feeling has a real basis. Renewed industrial activity will mean a rapid increase in the number of those exposed to occupational hazards. With increased strain and wear-and-tear among workers will come decreased leisure and less out-of-door recreation. Is there danger that the new period of greater industrial activity will be welcomed so eagerly that we may overlook human values? And perhaps most important of all are the curtailments and retrenchments which have been made in public health expenditures. What responsibilities have we in this direction? Will we be content to maintain our health machinery in its present restricted fashion, or will there be an expansion of necessary health services as our increased financial resources permit?

Fortunately, we in the public health field have solid ground to build upon. Of hard-earned knowledge, we have much. If applied, it would add greatly to our happiness and to the length of our lives. We know how, for example, to get completely rid of typhoid fever. Yet, each year, over 4,000 unnecessary deaths are caused by it and ten times that many cases still blot our record. Every child who dies of diphtheria is, in the present state of our knowledge, needlessly sacrificed. But even in 1933, there were at least 4,000 such deaths and perhaps as many as 60,000 cases. Another 14,000 babies have this year succumbed, most of them unnecessarily, to infantile diarrhea. Many of the fifty-odd thousand deaths from diseases of early infancy could have

been prevented. Tuberculosis claimed over 70,000 victims, and the complications associated with pregnancy caused the deaths of over 13,000 women. From half to two-thirds of all these costly tragedies could readily have been prevented. Accidents were responsible for over 85,000 fatalities. These and others that we might add, constitute a measure of the preventable toll. They account for nearly a quarter of a million valuable lives which, if saved, would have added greatly to our vital and economic resources.

Such deaths will be prevented during 1934, to the extent that the public health and public safety programs of our country are enabled to carry on with sufficient funds and adequate personnel. The present per capita expenditure for public health is estimated at close to 70 cents per annum. Fairly adequate health service cannot be supplied at less than $1.00 per capita—the approximate expenditure in 1930. The standard set by the AMERICAN PUBLIC HEALTH ASSOCIATION is $2.00 per capita per annum.

Let our New Year's health resolution for 1934 be to apply the knowledge that we have. Let us support with sufficient resources of money and good-will those programs of constructive health measures, both public and private, which have proved their worth. Let us not permit the health of our communities and our families to be jeopardized through indifference or through too much optimism that somehow our current momentum will carry us along indefinitely. We must advance!

The End of Prohibition and the Deathrate from Alcoholism

THE last five years of national prohibition have seen a continuous drop in the number of deaths from alcoholism. In 1929, the deathrate from alcoholism was 3.5 per 100,000 among wage-earners and their families insured in the Metropolitan Life Insurance Company. In 1933 (at the end of the third quarter), this figure was reduced to 2.1. The figure for the complete year 1933 will be lower than for any year since 1922. The advent of 3.2 per cent. beer has not been reflected in any increase in the number of deaths from alcoholism.

The course of the deathrate from alcoholism during the prohibition period presents a number of interesting points. At the beginning, in 1920, the deaths from ethyl alcoholism per hundred thousand of population was absolutely at the minimum. This cause of death then presented no problem. In fact, more deaths from acute poisoning by wood or denatured alcohol were reported, in the first year of national prohibition, than from alcoholism, the disease. But with ensuing years the acute poisonings decreased, while deaths from alcoholism, in the narrow sense, increased, until they reached a peak in 1926. Since that year, there has

been a practically steady tendency downward which will culminate in the favorable figure for 1933. In the general population of the United States Registration Area, the total number of deaths recorded as due to alcoholism for the period 1920 to 1932 was 45,549.

The short history of national prohibition illustrates the development of what looked like a serious health danger in our country. In a relatively short period, however, our people learned to adjust themselves, and the danger was reduced almost to the vanishing point.

The Needless Sacrifice of Mothers

IN VIEW of the notable advances made in various fields of preventive medicine in recent decades, it is regrettable that so little has been accomplished in the reduction of maternal mortality. During the last twenty years the general mortality has been reduced over 25 per cent.; infant mortality, at least 45 per cent.; and that from tuberculosis, about 65 per cent. In the more enlightened communities, today, typhoid fever, smallpox, the diarrheal diseases of infancy and many other former scourges of humanity are now well under control. Yet, in spite of increasing knowledge and practice of prenatal care, asepsis and sanitation; in spite of improved methods in obstetrics and the increased availability of modern hospital facilities, the deathrate of women in childbirth has shown almost no improvement for more than twenty years.

The maternal mortality rate in the United States Birth Registration States in 1915, the first year for which the figures are available, was 6.1 per 1,000 live births; in 1932, the same area showed a rate of 5.9, while the average rate for this area during the five-year period 1928-1932 was 6.0 per 1,000 live births. In the Birth Registration Area as a whole, the figure was even higher; in 1932, it was 6.4, and the average for the last five years was 6.7.

This phenomenon of high and stationary maternal death rates is not confined to the United States; it is discernable in practically every civilized country. A brief study of the accompanying table readily verifies this statement. During the World War and the influenza years of 1918-20, maternal mortality rates were consistently high in all countries. Since this was an abnormal period of stress and hardship, it is necessary to revert to previous years for data that will afford a just basis of comparison with post-war and post-influenza-pandemic years. The year 1910 has been selected for this purpose. Of the nineteen countries covered in this table, only three, Spain, Japan, and Switzerland, have shown any appreciable improvement in maternal mortality since 1910. In Spain, the rate has fallen about 32 per cent. as compared with 1910; in Japan, it has decreased about 25 per cent.; in

Switzerland, it has been reduced 20 per cent. since 1911. Lesser improvements of about 9 or 10 per cent. appear to have taken place in Ireland and Belgium. With these exceptions, the figures are very discouraging. In eight countries, namely, England and Wales, Scotland, Australia, Sweden, Denmark, Netherlands, Germany, and Italy, the maternal mortality rates have actually increased since 1910. There is nothing in this table to indicate that there has been any material improvement in conditions surrounding the puerperal state in Canada, Norway or Czechoslovakia. Finland seems to have accomplished some real betterment of these conditions, but in view of the fact that the death-rate increased in 1929 and that later figures are not at present available, it is impossible to determine whether this improvement was continued or merely temporary.

Every student of the subject knows that maternal mortality rates as published by the individual countries are not strictly comparable with each other. Various factors are responsible for this condition, namely, variations in the definition of live births; lack of uniformity in the classification of puerperal deaths which have been complicated with other causes; different bases of computation, such as live births, only, or total deliveries, etc.; and the degree of completeness with which births and deaths have been reported. Certain of these failings are present in the table on page 6 and for this very reason the reader is warned against accepting these rates too literally for purposes of comparison with each other. They are nevertheless fairly valid indices of the course of the maternal mortality rate in each country.

The chief obstacle to a comparison of international maternal mortality rates lies in the varying methods adopted by the individual countries in the selection of the primary cause of death in cases where pregnancy was associated with some other cause of death. For example, in the United States about 90 per cent. of such deaths are ascribed to the puerperal causes; in England and Wales, not much more than 75 per cent. are so classified; in Scotland somewhat over 80 per cent. are placed in this category, and in Ireland the percentage runs very close to that prevailing in the United States. Naturally, such variations of classification affect the comparability of the rates for these countries.

In the present study, the rates for England and Wales and for Ireland (Northern Ireland and Irish Free State combined) relate to all deaths wherein puerperal conditions were primary or associated causes. In this way the rates of these countries are brought more nearly in accord with those of the United States, but even so they are not strictly comparable, since it was not possible to tabulate the American data in exactly this way. An arbitrary addition of about 10 per cent. to the existing rates for the United States, would possibly overcome this difficulty. It is probable that the rates

recorded for Canada, Australia, and New Zealand are fairly comparable with those of the United States, although no positive information on this point is immediately available. On the whole, it may be said that the figures presented for each of the English-speaking countries in this table are fairly comparable. In this category, also, may be placed The Netherlands. Comparison with other countries, on the contrary, must be made with extreme caution as there appears to be wide divergence between their methods of classification of joint causes of death and those employed by the principal English-speaking countries.

Nevertheless, even after allowing for all of these variations in classification, registration, etc., it is fairly certain that the maternal mortality rate in the United States is higher today than in any other civilized country. The country that approaches nearest the United States in this respect is Scotland.

The failure to reduce maternal mortality not only in this country but throughout the world is incomprehensible, particularly, since it has been demonstrated on numerous occasions, both in the United States and abroad, that the mortality of women from causes connected with childbirth can be reduced materially, probably by at least two-thirds.

If another proof of this thesis were needed, it is supplied by a recent study of the COMMITTEE ON MATERNAL MORTALITY OF THE NEW YORK ACADEMY OF MEDICINE. The investigation was devoted mainly to those deaths which seemed preventable, and a careful review of every death established the fact that 1,343, or 65.8 per cent. of the deaths, might have been prevented "if the care of the woman had been proper in all respects."

Among its numerous conclusions and recommendations, the Committee stressed the need for better education and training of physicians and midwives, the need for prenatal care for prospective mothers, the relative safety of delivery at home, and recommended the adoption in hospitals of more rigid measures for the maintenance of asepsis in obstetrical cases.

It is noteworthy, that these very findings were foreshadowed a number of years ago in the report of the study made jointly by the MATERNITY CENTER ASSOCIATION OF NEW YORK and the Statistical Bureau of the Metropolitan Life Insurance Company. In this analysis of the records of 4,726 women cared for by the Association during the eight-year period, 1922 to 1929, it was found that by proper medical and nursing care the mortality from maternal causes could be reduced possibly to one-third of the prevailing rate. Inasmuch as over 13,000 lives of mothers were sacrificed in the United States, in 1933, on account of diseases arising out of pregnancy and childbirth, it should have been possible to save nearly 9,000 of them. Some day this needless sacrifice of mothers will stop.

Maternal Mortality per 1,000 Live Births in Selected Countries, 1910-1932

COUNTRY	1932	1931	1930	1929	1928	1927	1926	1925	1924	1923	1922	1921	1920	1919	1918	1917	1916	1915	1914	1913	1912	1911	1910
U. S. Expanding Birth Registration Area	6.4[1]	6.6	6.7	7.0	6.9	6.5	6.6	6.5	6.6	6.7	6.6	6.8	8.0	7.4	9.2	6.6	6.2	6.1	*	*	*	*	*
U. S. Reg. Area of 1915[2]	5.9	6.1	5.9	6.1	6.1	6.2	6.2	6.2	6.2	6.4	6.2	6.5	7.6	6.8	8.9	6.3	6.2	6.1	*	*	*	*	*
England and Wales	5.4	5.6	5.6	5.8	5.6	5.4	5.1	5.2	5.1	4.8	5.2	5.0	5.5	6.3	7.6	4.8	5.1	5.3	5.1	4.9	5.0	4.9	[3]
Scotland	6.4	5.9	6.9	6.9	7.0	6.4	6.4	6.6	5.8	6.4	6.6	6.4	6.2	6.2	7.0	5.9	5.7	6.2	6.0	5.9	5.5	5.7	5.7
Canada (Reg. Area of 1921)	5.0	5.2	5.9	5.9	5.8	5.9	5.9	5.6	6.0	5.4	5.5	5.1	*	*	*	*	*	*	*	*	*	*	*
Australia	5.6	5.5	5.3	5.1	6.0	5.9	5.3	5.6	5.5	5.1	4.5	4.7	5.0	4.7	4.7	5.6	5.3	4.3	4.6	4.9	4.8	5.0	5.1
Total Ireland	*	*	5.4	5.3	5.7	5.4	5.6	5.2	5.3	5.6	6.1	5.6	6.3	5.9	5.8	5.5	6.1	6.0	5.6	5.8	5.9	5.7	5.9
Northern Ireland	*	6.6	6.1	6.3	6.5	6.5	6.2	5.5	5.4	6.1	5.9	...	...	...	...	...	...	...	...	...	...	...	...
Irish Free State	*	*	5.0	4.9	5.4	4.8	5.4	5.0	5.2	5.3	6.3	...	...	...	...	...	...	...	...	...	...	...	...
Norway	*	2.7	3.0	3.6	3.0	2.4	3.2	2.7	2.9	2.8	2.5	2.2	2.6	3.4	2.4	3.0	2.8	2.7	3.3	2.6	3.0	3.1	2.7
Sweden	2.7	2.9	3.5	3.8	3.3	2.8	2.9	2.6	2.4	2.3	2.5	2.7	2.7	3.2	2.6	2.5	2.7	2.9	2.6	2.3	2.3	2.7	2.5
Denmark (urban population only)	*	3.7	3.7	2.9	3.0	3.1	2.2	2.7	2.8	2.7	2.4	2.2	2.4	3.3	1.8	1.9	2.2	2.1	1.8	1.5	2.0	2.6	1.9
Germany	*	5.1	5.4	5.5	5.5	5.2	4.9	5.0	5.3	5.2	5.0	4.9	4.9	5.1	4.9	4.5	4.5	4.0	3.6	3.4	3.5	3.5	3.2
Switzerland	*	4.4	3.7	4.6	4.4	3.7	4.4	4.3	4.8	4.6	5.1	5.5	5.6	5.7	5.1	5.6	5.4	5.5	5.3	4.9	5.2	5.5	4.8
Netherlands	3.0	3.2	3.3	3.4	3.4	2.9	2.9	2.6	2.4	2.3	2.5	2.3	2.4	3.4	3.0	2.5	2.6	2.5	2.1	2.1	*	*	*
Belgium	*	5.0	5.3	6.2	6.1	5.7	6.1	5.0	5.8	5.7	5.4	5.8	6.1	7.2	*	*	*	*	*	5.6	6.6	6.0	5.5
Italy	*	*	2.7	2.9	2.8	2.6	2.6	2.8	3.2	2.7	2.5	2.6	2.8	2.9	3.7	3.0	2.7	2.2	2.4	2.5	2.4	2.4	2.4
Spain	*	*	3.6	3.6	4.0	3.9	3.8	4.0	4.4	4.6	4.9	5.1	5.0	5.3	6.4	5.0	5.1	5.2	5.3	5.3	5.3	5.2	5.3
Czechoslovakia	*	*	4.1	4.3	4.2	3.9	3.6	3.7	3.1	3.2	3.4	3.7	4.0	3.7	*	*	*	*	*	*	*	*	*
Japan	*	*	2.7	2.8	2.8	2.8	2.7	3.0	3.1	3.4	3.3	3.6	3.5	3.3	3.8	3.5	3.5	3.6	3.5	3.4	3.3	3.5	3.6
Finland	*	*	*	3.6	3.0	3.0	3.2	2.9	3.5	3.1	3.0	*	3.6	4.0	4.4	3.8	3.6	3.4	4.1	3.9	3.7	4.3	3.7
New Zealand	4.1	4.8	5.1	4.8	4.9	4.9	4.3	4.7	5.0	5.1	5.1	5.1	6.5	5.1	5.2	6.0	5.9	4.7	4.2	3.6	3.6	4.3	4.5

*Data not available.

[1] Exclusive of Utah.

[2] Births and deaths for 1930, 1931, and 1932 from Provisional Statistics, U. S. Census Bureau, except Mass. and D. C. births, which were taken from Mass. and D. C. Annual Reports.

[3] Data not comparable with that for later years.

Where the Diphtheria Deathrate Is Still High

NO SINGLE development in the entire field of public health has been more widely acclaimed than has the reduction in the mortality from diphtheria. This disease in the country, as a whole, has become a very minor cause of death. Its deathrate (4.5 per 100,000 in 1932) is only a small fraction of the figure recorded at the beginning of the century. What is not so generally known is that there are still a number of states and large cities where the diphtheria mortality is today not only atrociously high, but is actually increasing.

There were four States in 1932 which registered diphtheria deathrates in excess of 13 per 100,000; and in every one of them the 1932 figure was much higher than that recorded two years previously. In New Mexico, which had the highest diphtheria mortality rate in the country, the 1932 figure was actually 34 per cent. higher than prevailed for the United States* *ten* years previously. In Kentucky, West Virginia and Oklahoma, the diphtheria deathrate of 1932 was not far from the average throughout the country, ten years ago, despite the fact that since that time there has been a reduction of nearly 70 per cent. in the diphtheria mortality rate of the country at large.

In most sections of the country, at least one and usually several States are found where deaths from diphtheria are still high and increasing. New England, the Middle Atlantic States and the Pacific Coast States are the only exceptions. The worst regional picture is that of the four East South Central States, Kentucky, Tennessee, Alabama and Mississippi. Kentucky, in 1932, not only had the second highest diphtheria deathrate in the entire country, but recorded a rise of 66 per cent. in two years. Tennessee had the sixth highest mortality rate, and the increase since 1930 was 28 per cent. Alabama and Mississippi ranked seventh and eighth respectively; but here the situation is not quite so bad, as the rise in Alabama, since 1930, was small and in Mississippi there was a slight decrease. The diphtheria situation in Oklahoma, Arkansas and Louisiana, in the West South Central region, is deplorable. Oklahoma had the fourth highest rank in the country and the rise in two years amounted to 47 per cent.; Arkansas ranked fifth, with a rise of 77 per cent. and Louisiana tenth with an increase of 37 per cent. In the South Atlantic region, West Virginia had the third highest diphtheria deathrate of all the States, and the mortality more than doubled in two years. Every other State in this section of the country, save Maryland, had an above-average diphtheria deathrate in 1932. Nevertheless, there is evidence of improvement in Virginia, South Carolina, Florida and North

*Registration area of 1922.

[3] Data not comparable with that for later years.

Carolina since 1930. In Georgia the trend was upward.

In the Mountain States, there are sharp contrasts between the diphtheria mortality rates of the several commonwealths. New Mexico had the very highest diphtheria deathrate in the entire country, and showed a rise of 70 per cent. in two years; Nevada ranked eleventh, and its 1932 rate was almost triple that of 1930. On the other hand, low rates prevailed in Idaho, Montana, Wyoming and Colorado.

Missouri was the only State in the West North Central group, and Indiana the only one of the East North Central region to register a high and increasing diphtheria mortality rate during the last three years.

There were 32 large cities in 1932 which had diphtheria mortality rates above the average for the country (4.5 per 100,000). The worst situation was in Knoxville, where the rate was 17.0 per 100,000, followed closely by Dallas, with 16.6. Four other cities, Fort Worth, Peoria, Lowell and Oklahoma City exhibited rates in excess of 10 per 100,000.

States and Large Cities Recording, in 1932, Deathrates for Diphtheria, Higher Than the Average for the Registration Area. 1932 and 1930 Compared.*

State or City	Deathrate per 100,000 Population		City	Deathrate per 100,000 Population	
	1932	1930		1932	1930
New Mexico	19.5	11.5	Camden	8.4	12.6
Kentucky	13.8	8.3	Wichita	8.4	4.5
West Virginia	13.4	6.0	Dayton	7.7	1.5
Oklahoma	13.2	9.0	Memphis	7.6	5.5
Arkansas	9.9	5.6	Des Moines	7.5	2.1
Tennessee	9.2	7.2	Miami	7.3	3.6
Alabama	7.8	7.5	Chattanooga	7.2	3.3
Mississippi	7.5	8.2	Houston	7.1	4.7
Missouri	7.4	4.5	Nashville	7.0	11.7
Louisiana	6.7	4.9	Los Angeles	6.9	5.7
Nevada	6.5	2.2	San Antonio	6.9	7.7
Georgia	6.3	5.0	Erie	6.7	2.6
Virginia	6.0	7.1	Tulsa	6.7	2.1
Indiana	5.4	4.3	Fort Wayne	6.6	0.9
South Carolina	5.2	7.4	Denver	6.4	3.5
Florida	5.2	5.5	Jacksonville	6.4	6.2
North Carolina	5.1	8.9	Providence	6.0	7.9
Delaware	5.0	8.4	Worcester	6.0	4.6
			New Orleans	5.9	8.3
			Omaha	5.9	6.1
Knoxville	17.0	4.7	Paterson	5.8	9.4
Dallas	16.6	6.5	El Paso	5.6	9.7
Fort Worth	13.5	4.3	Evansville	4.7	4.9
Peoria	13.5	6.6	Atlanta	4.6	1.1
Lowell	11.0	4.0	Tampa	4.6	2.9
Oklahoma City	10.2	6.9	Youngstown	4.6	7.0

*4.5 per 100,000 Estimated Population.

Inspection of the table on page 8 reveals that conspicuously high deathrates prevailed in 1932 in one or more large cities in practically every section of the country.

A summing up of the distinctly unfavorable aspects of the diphtheria situation shows that there were 18 States which recorded, in 1932, diphtheria deathrates in excess of the average for the United States in that year. In 12 of these States the situation is getting worse instead of better, as is shown by comparison of their 1932 deathrates with those recorded two years earlier. Furthermore, in 22 of the 32 large cities whose 1932 diphtheria mortality rates were above the average for the country, the 1932 figures were higher than those for 1930.

It is difficult to understand how whole States and certain cities can justify their administration of the public health facilities to permit the continuance of high and increasing diphtheria rates at the very time when a marked reduction is going on in the country at large, and all over the civilized world. Diphtheria would soon be banished altogether if immunization by toxin-antitoxin or toxoid were extended to include all susceptible children.

Health Record for November, 1933

NOVEMBER, like October, registered a higher deathrate than prevailed for the corresponding month of 1932. The effect has been to raise the crude deathrate for the first eleven months to a point 3.2 per cent. higher than for the like period of last year. The showing for the year, to date, is nevertheless excellent; for it must be borne in mind that the comparison is with 1932, the record health year of all time among American and Canadian wage-earners. Furthermore, when we take into account the fact that the current year got a bad start, and that its low deathrate relates to a period of economic unrest and widespread unemployment, it is indeed remarkable that the 1933 mortality rate is as low as it is, and, more especially, that it is below the average for the last ten years.

The deathrate for November (8.6 per 1,000) is nevertheless the highest recorded for that month since 1920, although the identical figure was registered in November, 1927. An unusually large number of deaths from the chronic degenerative diseases and from the respiratory conditions occurred during November of the current year.

One of the most favorable items in the 1933 health record is a drop of 4.5 per cent. in the mortality among the Canadian Industrial policyholders of the Metropolitan.

Even before the close of the year, the facts are sufficiently clear-cut to safeguard the prediction that 1933 will mark new low points in the mortality from typhoid fever, diphtheria, tuberculosis, diarrheal diseases and conditions incidental to pregnancy and childbirth. It is quite

probable, also, that a new minimum for pneumonia will be reported this year. On the other hand, no doubt remains that the highest mortality rates in the history of Metropolitan Industrial policyholders will be registered for diabetes, cancer and organic heart disease.

The deathrate in the general population of the large cities of the United States for the month of November was 11.1 per 1,000 estimated population as compared with 10.2 in October and 10.7 in November of last year. The diseases which showed increased prevalence during November as compared with October were influenza, measles, scarlet fever and smallpox; there were fewer cases of diphtheria, poliomyelitis and typhoid fever. Comparison with November, 1932, shows more sickness this year from diphtheria, measles, poliomyelitis, scarlet fever and typhoid fever, but fewer cases of influenza and smallpox.

The following items are of special public health interest. The AMERICAN MEDICAL ASSOCIATION has appointed a committee to draw up plans whereby medical, social and public health authorities may effectively work together to prevent congenital syphilis. The COMMITTEE ON CANCER EDUCATION of the COLORADO STATE MEDICAL SOCIETY is soon to inaugurate a five-year program on cancer education, particularly with reference to cancer of the breast. A health survey of New Mexico is being undertaken by the AMERICAN PUBLIC HEALTH ASSOCIATION with the cooperation of the NEW MEXICO TUBERCULOSIS ASSOCIATION, the U. S. BUREAU OF INDIAN AFFAIRS and the AMERICAN SOCIAL HYGIENE ASSOCIATION. A one-day census of venereal diseases under treatment is a feature of this survey. Five Kansas counties have had county-wide conferences for handicapped children. These conferences were sponsored by scientific organizations; and it is reported that 93 per cent. of the children examined were found to be in need of medical or dental treatment; 33 per cent. showed evidence of malnutrition and there was a similar ratio of those who had defective vision, while 53 per cent. had diseased tonsils and adenoids. Responding to a request from the Chinese Government, the LEAGUE OF NATIONS has sent the Director of its Health Organization to China for a year, as a delegate to aid that country in its plan of reconstruction. In order to obtain data on the prevalence of amebic dysentery, the UNITED STATES PUBLIC HEALTH SERVICE has requested health officers to report promptly all cases of the disease. More than 12,000 Connecticut children have had roentgenograms made since the State Health Department began its campaign against tuberculosis, in October. The program is under way in more than 100 cities and towns, with the emphasis on detecting tuberculosis in the early stages.

The following table shows the mortality among Industrial policyholders for November, 1933; October, 1933, and November, 1932, together with the cumulative rates for the first eleven months of each year.

METROPOLITAN LIFE INSURANCE COMPANY

Deathrates per 100,000 for Principal Causes. Weekly Premium-Paying Business in Industrial Department. All Ages (Annual Basis).*

MONTHS OF NOVEMBER, 1933; OCTOBER, 1933, AND NOVEMBER, 1932

CAUSES OF DEATH	ANNUAL RATE PER 100,000 LIVES EXPOSED*				
	Nov. 1933	Oct. 1933	Nov. 1932	Cumulative January-November	
				1933	1932
TOTAL—ALL CAUSES	859.2	811.6	815.9	875.3	848.3
Typhoid fever	1.9	2.8	2.2	1.6	1.7
Measles	.5	.2	.4	1.6	1.8
Scarlet fever	2.2	1.5	2.1	2.6	2.8
Whooping cough	1.9	1.7	1.6	2.4	3.1
Diphtheria	4.7	4.1	4.3	2.5	3.8
Influenza	9.6	6.7	9.6	20.8	17.1
Tuberculosis (All forms)	53.5	60.5	63.9	65.8	69.8
Tuberculosis of respiratory system	48.4	54.6	56.5	58.8	61.6
Cancer (All forms)	97.0	98.4	95.5	95.4	89.8
Diabetes mellitus	25.3	23.2	24.1	24.3	22.5
Cerebral hemorrhage; apoplexy	67.9	62.1	64.1	65.0	61.9
Diseases of heart†	161.7	149.2	145.4	163.5	153.8
Pneumonia (All forms)	65.3	41.4	55.4	62.3	63.2
Other respiratory diseases	11.6	10.4	10.4	10.2	9.2
Diarrhea and enteritis	9.9	17.1	9.4	11.1	11.6
Chronic nephritis (Bright's disease)	68.8	62.9	66.3	68.2	67.3
Puerperal state—Total	8.1	7.4	8.8	9.4	10.5
Suicides	8.2	8.9	8.4	10.1	10.7
Homicides	7.0	6.5	6.6	6.2	6.1
Accidents—Total	56.0	56.2	51.1	56.8	54.7
Automobile accidents	22.4	23.2	20.3	19.8	18.8
All other diseases and conditions	198.1	190.3	186.4	195.3	186.9

*The rates for 1933 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk.

†Excludes pericarditis, acute endocarditis, acute myocarditis and angina pectoris.

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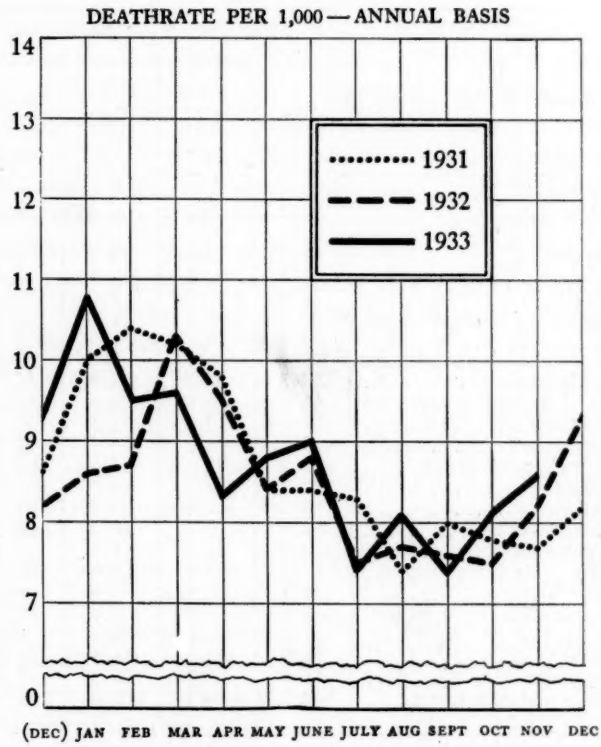
STATISTICAL BULLETIN,
Metropolitan Life Insurance Company,
1 Madison Avenue, New York City.

DEATHRATES FROM ALL CAUSES

in the Metropolitan Life Insurance Company
Industrial Department



1931	10.0	10.4	10.2	9.8	8.4	8.4	8.3	7.4	8.0	7.8	7.7	8.2
1932	8.6	8.7	10.3	9.5	8.4	8.8	7.5	7.7	7.6	7.5	8.2	9.3
1933*	10.8	9.5	9.6	8.3	8.8	9.0	7.4	8.1	7.4	8.1	8.6	

* *Rates for 1933 are provisional.*

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